Strategic Plan 2007-2011

Aging & Disability Services Administration

Washington State
Department of Social
& Health Services

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July 1, 2006

Purpose of This Document

This strategic plan communicates how we will advance our mission and goals in a changing environment and meet our future challenges, so that we can better serve the most vulnerable populations in Washington State. This document is a road map that guides the business policies and improvement strategies for our organization, employees and partners.

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Executive Summary

The populations served by the Aging and Disability Services Administration are growing and their needs are becoming more complex. At the same time, funding for all government services is stretched thin and there is unlikely to be significant new governmental funding available.

Washington State's long-term care policy has a history of respect for the autonomy of the individual and the role of informal caregivers. Washington's policymakers have developed a balanced array of quality services available for seniors and people with physical or developmental disabilities when state-paid services are required. ADSA has been a prudent manager of scarce resources, directing services to those most in need while respecting the individual's service preferences. The challenge for the state in the next several years will be to build upon these commitments, making improvements in targeted areas even in light of growing need and likely stagnant funding.

Two areas of particular focus will be preparing for a huge increase in demand for long-term care services as the Baby Boomers become senior citizens, and better assisting people with developmental disabilities to be integrated into their communities. The strategies discussed in this plan are those that ADSA believes are consistent with our mission and authority. They are organized to accomplish the following broad goals:

- Maintaining an appropriate balance between institutional services and home and community services to ensure that individuals are able to receive services in the most appropriate, preferred setting possible.
- Supporting informal care for persons with disabilities and older persons who need long-term support.
- Expanding our vision to include helping Washington's citizens plan for future care needs such as doing financial planning, engaging in health promoting behaviors, and benefiting from early intervention.
- Improving upon the already strong performance of programs that monitor the quality of care, quality of life, safety of vulnerable children and adults, and accountability of programs.
- Continuing to develop programs to respond holistically to individual needs.

The strategic plan also includes the necessary management and infrastructure strategies to accomplish these programmatic goals.

The plan provides an overview of ADSA's mission and legal authorities in Chapter 1. In Chapter 2, we describe the ADSA organization and the services we provide. Chapter 3 discusses client characteristics and anticipated changes in the external environment. In Chapter 4 we list the goals, objectives, and strategies we propose to address issues and the performance measures we will use to determine if we are achieving our goals. Chapter 5 provides informational charts about current ADSA programs.

Chapter 1 ● Our Guiding Directions

MISSION

The Aging and Disability Services Administration (ADSA) assists adults with disabling conditions due to aging, disease or accident and children and adults with developmental disabilities to gain access the high quality, cost effective supports they need.

VISION

ADSA helps individuals and their families improve quality of life, develop and maintain self-sufficiency, and remain contributing members of their community. We guide a system of services that are high quality, responsive to individual needs and preferences, and cost effective.

We achieve success by supporting individuals, families and caregivers; expanding service options; and continuously improving quality of care and support in all settings. The supports and services we deliver are based on each individual's unique strengths and needs.

We contain overall costs by promoting prevention and self-reliance, reducing unnecessary use of more expensive services, and preventing or reducing the need for future services or resources.

Within Medicaid programs we are developing an increasingly integrated social and health care program. Our objective is a system that delivers seamless medical, habilitative, mental health, long-term care, employment and supportive services in the person's own community.

ADSA programs are accountable for high standards of preventative care. We use chronic care management practices that are outcome oriented and evidence based. In addition, ADSA's programs demonstrate superior service quality, community integration, continuity of care and support, economic value, and consumer satisfaction.

GUIDING PRINCIPLES AND VALUES

ADSA Values:

- Individual worth, dignity, respect, self-direction, self-reliance, choice, and ability to accept responsibility and risk.
- Right to be free from abuse, neglect, abandonment, financial exploitation, and discrimination.
- An individual's social and health needs are strongly linked.
- Family caregivers have a critical role in providing support.
- Prudent management of state and federal resources including use of outcome-oriented, accountable, efficient, research-based practices for maximum public benefit.

ADSA Guiding Principles:

- Individual choice and self-direction are supported by professionals – not replaced by them.
- Services and supports enable people to remain in their own home and community whenever possible.
- Support for families and caregivers that improve client outcomes.
- Appropriate prevention, health management, and intervention services and policies to help alleviate future crises, improve individual and family capacity for independence, and reduce the need for future, more expensive and less preferred services.
- A cost-effective array of services to respond to diverse needs and preferences.
- Monitoring quality, safety, and accountability of federal and state licensed/certified residential care programs in the interest of residents, regardless of payment source.
- Clear and consistent policies and procedures necessary to produce a reliable, accountable service system.
- Services and supports that are culturally and linguistically appropriate for both clients and employees.

STATUTORY AUTHORITY

- The Federal Older American's Act authorizes a network of local Area Agencies on Aging (w/citizen advisory councils), as well as home/community services.

- Title XIX of the Social Security Act authorizes nursing facility services and the COPES, Medically Needy, and DD waivers, which authorize home and community-based services as an option to nursing facility or institutional services.

- Titles XVIII & XIX of the Social Security Act authorize Nursing Facility Survey to ensure consumer protection and quality of care.

- 42 CFR 483.400 authorizes services in ICF/MR facilities.

- Americans with Disabilities Act of 1990 (ADA) ensures equal access for individuals with disabilities.

- Public Law 105-17; The Individuals with Disabilities Education ACT (IDEA), Part C governs Infant, Toddler Early Intervention Services.

- 34 CFR 303 regulates the Early Intervention Program for Infants and Toddlers with Disabilities.

- RCW 74.04.025 authorizes services for Limited English Proficient applicants and recipients of services.

- RCW 74.39.050 authorizes self-directed care.

- Chapter 18.51 RCW authorizes the nursing facility license functions.

- Chapter 18.20 RCW authorizes the boarding home license functions.

- Chapter 74.46 RCW authorizes the nursing facility payment system.
- Chapter 74.42 RCW authorizes nursing facility case management associated with voluntary relocation of residents who wish to be served in community settings.
- Chapter 74.39 RCW authorizes in-hospital LTC assessment.
- Chapter 74.39A RCW authorizes COPES Medicaid Waiver, assisted living, personal care, chore services, Adult Residential Care and LTC quality improvement.
- Chapter 70.128 RCW authorizes the Adult Family Home program.
- Chapter 74.39A RCW authorizes in-home case management by Area Agencies on Aging.
- Chapter 70.195 RCW establishes the State Interagency Coordinating Council for Infants and Toddlers with Disabilities and their families. It also establishes County Interagency Coordinating Councils and requires state and local interagency agreements to define early intervention roles and responsibilities.
- Chapter 74.14A RCW establishes policy for children with emotional disturbances and mental illness, potentially dependent children, and families in conflict.
- Chapter 74.38 RCW (The State Senior Citizens' Services Act) authorizes home and community-based services.
- Chapter 74.34 RCW governs protection of vulnerable adults from abuse and neglect.
- Chapter 74.41 RCW authorizes Respite Services and the Family Caregiver Support Program.
- Chapter 18.18A RCW authorizes delegation of selected nursing functions.
- Title 71A provides for services to persons with developmental disabilities, including coordinated state and local programs.
- Washington State Constitution – Article XIII, Section 1 authorizes institutions for the benefit of persons with developmental disabilities.

Chapter 2 ● The ADSA Organization and Services Provided

THE ADSA ORGANIZATION

ADSA brings together under one administrative organization, the major long-term care and supportive service programs designed for children, seniors, and adults with disabilities, developmental delays or disabilities, cognitive impairment, chronic illness and related functional disabilities. The array of services includes information and assistance; assessment; service planning; case management; chronic care management (in some locations); referral; early intervention and prevention services; employment services; home and community support and services; family and caregiver support and respite; a wide range of community-residential care options; nursing facilities; and residential habilitation centers for persons with developmental disabilities. Services are delivered either directly by ADSA employees or through partnerships with counties, Area Agencies on Aging, contracted agencies and providers.

ADSA administers a budget of approximately $4.1 billion per biennium and directly employs approximately 4,500 people to provide services for individuals in all stages of life, from birth throughout life. The following is a brief description of some of the services we provide. Chapter 5 of this plan provides a snapshot of the numbers of clients and providers, and average payment rates for ADSA's core services.

DESCRIPTION OF SERVICES

ADSA provides services to Washington State citizens ranging from birth to death. The Infant Toddler Early Intervention Program (ITEIP) serves approximately 7,400 children, birth to three years, and their families.

ADSA projects an average monthly Medicaid long-term care (LTC) caseload of approximately 48,000 seniors and adults with disabilities. Almost seventy percent of these clients are over age 65 with 30 percent aged 18-64. An individual must have a substantial unmet need for assistance with an Activity of Daily Living (ADL) such as eating, dressing, or mobility to qualify for Medicaid services.

The administration anticipates providing case management for almost 35,000 individuals with developmental disabilities and arranging for paid services for approximately 20,000 of these clients. Approximately 42% of persons receiving services from the Division of Developmental Disabilities are under age eighteen, 55% are adults between the ages of 18 and 64, and 3% are adults older than 65.

In addition to providing for direct services to individuals eligible for Medicaid or state funding, ADSA provides quality assurance for all community-residential and nursing facilities, regardless of the resident's payment source.

Many of the services described below receive substantial funding from the Medicaid program. The federal and state governments share in the cost of Medicaid services. The federal government provides approximately 50% of the funding for Medicaid services and does not place specific limits on the amount of funding available. As long as the state provides its share of funding, the federal government will provide its matching share. As a result, most states have tried to expand the use of Medicaid services.

Some Medicaid services such as nursing homes are considered "entitlements" that is, anyone who meets established criteria must be served. Some Medicaid services are provided under a "waiver" which allows the state to establish a waiting list of people who qualify for the service in cases where funding is not available. In Washington State, funding is relatively flexible for long-term care programs and the service package has been managed so that waiting lists have not been necessary. For example, ADSA has been able to reduce nursing home Medicaid caseloads and use the savings to fund additional home and community services. The DDD budget is less flexible, making it more difficult to authorize services in categories where specific funding is not available.

Other programs described in this chapter such as Information and Assistance, Family Caregiver Support, Employment, Respite, etc. are more heavily state funded making it more difficult to expand these services.

Information and Assistance and Case Management

ADSA provides Information and Assistance (I & A) and Case Management services to ensure that individuals and families receive assistance identifying and understanding their options as they plan for their care and support needs. Another critical responsibility is to ensure that care provided through state- or Medicaid-funded services is managed with a goal of obtaining appropriate, good quality, cost-effective services.

Social workers and case managers assess the needs of individuals and their families and connect them to available supports and services. They coordinate planning and development of resources, authorize payment for any state- or Medicaid-funded services, monitor and review service delivery, provide information about available services, refer persons to other sources of support, and assist individuals in crisis by linking them to resources.

Case management/information and assistance functions are handled differently as we work with persons with developmental disabilities then they are as we work with seniors or younger persons with physical disabilities.

Case managers in the Division of Developmental Disabilities (DDD) provide information and assistance and determine eligibility for DDD services. They provide case management services for individuals who may or may not receive services funded by the state. "Developmental disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other intellectual disability requiring similar services. To be eligible for services through the DDD, the disability must have originated before age eighteen, be expected to continue indefinitely, and constitute a substantial handicap to the individual.

For long-term care services, case management is focused on persons receiving state or Medicaid funded services. ADSA employees throughout the state assess individual needs, and determine financial eligibility, develop service plans, and refer clients to services for state-funded long-term care programs. If an individual is determined eligible for state- or Medicaid-funded long-term care in their own home, ongoing functional eligibility, service planning, case management, and monitoring are provided by the local Area Agency on Aging. If an individual is determined eligible for state- or Medicaid-funded long-term care provided in a community residential setting such as a boarding home or adult family home, or in a nursing home, state employees provide service planning, ongoing case management and monitoring.

The broader information and assistance (I&A) function for seniors age 60 and older and their families who need access to community services that may or may not be government funded, including long-term care services, is provided through contracts with Area Agencies on Aging statewide.

The federal government is interested in improving accessibility to information and assistance and has provided grants to several states, including Washington, to develop an "Aging and Disability Resource Center" (ADRC) pilot site. This grant will test a model in which one agency provides information and assistance for all individuals with disabilities of all ages. The vision is to have Resource Centers in every community serving as highly visible and trusted places where people can turn for information on the full range of long-term support options. The centers will also be a single point of entry to public long-term support programs and benefits. The centers will be a resource for both public and private-pay individuals. They will serve older adults, younger individuals with disabilities, family caregivers, as well as persons planning for future long-term support needs. The Centers will also be a resource for health and long-term support professionals and others who provide services to older adults and to people with disabilities. Pierce County is ADSA's partner and pilot site for this grant.

Early Intervention and Prevention Services for Children

Early Intervention Services are intended to enhance the development of eligible infants and toddlers and the capacity of families to meet the special needs of their children. The Infant Toddler Early Intervention Program (ITEIP) coordinates existing early intervention services for approximately 7,400 children ages birth-to-three and their families during a year (more than 4,000 children and their families are served on an average day). The program assures that federal service standards are followed. These services include family resources coordination, therapies, and family training and counseling for children age birth to three with developmental delays or disabilities, and their families.

This program allows families to access early intervention services statewide in their local communities. ITEIP contracts with locally-designated lead agencies to ensure statewide service delivery, a multi-agency system, and data collection mechanism. Local Lead Agencies responsible for services within their geographical area hire Family Resources Coordinators who assist families through a community team process to complete an Individualized Family Service Plan (IFSP). The IFSP defines services, settings and funding sources to assist in meeting the developmental needs of the child.

Local resources are essential in providing necessary services. But local resources may be limited. Washington's legislature recently passed a bill requiring that by 2009 all school districts will provide early intervention services for children ages birth to three in coordination with local lead agencies and other available community resources. It is likely that there will be discussions in the future about strengthening the participation requirements of counties in early intervention programs.

Approximately 70 percent of the children served are eligible for Medicaid services. Over 20 percent of all infants and toddlers, served by ITEIP no longer need special education services as they exit the ITEIP program.

Employment and Day Programs

Approximately 40 percent of adults enrolled by DDD are involved in an employment or day program. DDD supports employment and day services, including child development

services, through contracts and partnerships with county governments. The counties select and contract with service providers or directly provide many of the employment and day services. Services include:

- Employment services that provide ongoing support for persons with paid jobs.
- Community access services to assist individuals to participate in activities, events and organizations in the local community in ways similar to others of retirement age.
- Child development services that are coordinated with the Infant Toddler Early Intervention Program, including therapy, education, family counseling, and training provided to children until age three when they become eligible for programs through public schools or other community programs.
- Person-to-person services, which help individuals articulate a personal vision for life in the community including employment, and locate sources of personal support in the community to enhance that vision.
- Time-limited individual and family assistance services to help individuals and families use natural and informal community supports.
- Information and education services to assure that individuals and families have current information about supportive services.
- High School Transition, which works with school districts to prepare individuals with developmental disabilities who are leaving high school for employment opportunities.

In 2004, the Division of Developmental Disabilities issued a "working age adult policy" establishing employment supports as the primary use of employment/day program funds for working age adults. The policy is intended to focus county authorized services on supports to pursue and maintain gainful employment in integrated settings in the community. Community access is being focused on older adults (over age 62) who have retired from work. The working age adult policy will be fully implemented in July 2006.

In-Home Services

In-home services provided through ADSA are largely funded by Medicaid, and are available statewide. Services are structured to allow an individual to remain living in his or her own home rather than moving to a residential facility. Services include assistance with activities of daily living, as well as necessary home modifications, emergency response devices, adaptive devices or equipment, delegated or directly provided nursing services, and training of participants in addressing their needs. Personal care assistance is provided either by an Individual Provider (IP) who is hired directly by the person needing assistance or by a caregiver who works for a licensed and contracted home care agency. Other types of in-home services are provided through contracts managed by Area Agencies on Aging. ADSA pays for services for eligible individuals.

Residential Services

Residential services provided through ADSA are also largely funded by Medicaid. They are available statewide although program managers report a need for more resources that serve persons with special needs such as behavioral, mental health, and chemical dependency needs. Additionally, more resources are necessary in some of the more rural counties.

The most commonly used residential options include group homes, adult family homes, boarding homes, community Intermediate Care Facilities for the Mentally Retarded (ICF/MR), State Operated Living Alternative (SOLA), and supported living programs. Residential settings may be licensed facilities (boarding homes, adult family homes,

group homes, ICF/MRs) or smaller, certified or contracted settings in which individuals may share housing and services (SOLA, supported living, companion homes). Services in residential settings may include supervision, personal care, room and board, and limited nursing. In addition to providing direct care, residential providers may help people with developmental disabilities learn new skills such as shopping, cooking, managing money, and using community resources.

Residential options range from small (1-2 individuals) to large (boarding homes have on average of 46 beds). ADSA contracts with providers of the various residential options for services for individuals who are eligible for Medicaid.

The Community Protection program provides intensive 24-hour supervision for individuals with developmental disabilities who have been identified as being a danger to their community due to crimes they have committed. This program provides an opportunity for participants to live in the community and remain out of prison or other justice settings. Safeguards are in place to protect neighbors and community members, to the extent possible. Case managers work with a team of professionals including the provider to develop supports that may eventually enable the individual to live in a less restrictive setting. Case management for these individuals is particularly challenging. In some regions, case managers have difficulty meeting requirements for periodic reviews of client progress. Additionally, the numbers of individuals who might be served in the program is growing as policy makers look for alternatives to criminal justice settings.

Other residential options include nursing homes and Residential Habilitation Centers (RHCs). While these more institutional settings will likely remain important services in the future, discussions are necessary about how much investment should be made in these areas.

Most nursing homes are privately-operated facilities, licensed by the state, and contracted with ADSA to provide services for individuals who are eligible for Medicaid. The nursing home occupancy in 2004 was 87%. There is a need for discussion about whether the nursing home bed need ratio should be revised downward.

Residential Habilitation Centers (RHCs) are state-operated facilities that serve persons with developmental disabilities. They may be certified as ICF/MRs or as nursing facilities. There has been ongoing policy discussion about whether or not to continue operating all five RHCs. At this time, the decision has been made to keep all five facilities open but this will require significant capital investments to maintain state and federal certification requirements.

The 2005 Legislature passed a bill (E2SSB5763) creating a new type of ADSA licensed facility to be called an Enhanced Services Facility (ESF). The ECS license would allow providers to offer services that can accommodate the needs of individuals whose behaviors or recent history makes them ineligible to be safely served in another type of community residence. The budget did not include funding to develop the program or operate such a facility. This plan includes strategies for implementing this new type of facility.

Informal Caregiver Support and other services

Informal, unpaid caregiving is a critical piece of the long-term care system. Family and other unpaid caregivers provide nearly 80% of all long-term care in this country. In Washington State, it is estimated that more than 570,620 family caregivers provide

611,000,000 hours of care at a value of over $5.4 billion helping adults (18 years and older) who have chronic illnesses or serious disabilities. Caring for an ill or disabled family member can be physically demanding and exhausting, and can leave the caregiver feeling overwhelmed, frustrated, or fearful.

Unlike the Medicaid funded programs, supportive services for informal caregivers are not considered "entitlements". Funding is largely provided by the state and, once funds are spent, people in need may go without services.

However, studies suggest that relatively low-cost family caregiver supportive services can not only reduce the stress experienced by family caregivers, but can result in delayed placement in more expensive services for the person needing care. A recent study in Minnesota found that each dollar spent in family support/respite programs saved $8 in future long-term care services. This strategic plan includes steps to seek additional funding for services to support informal caregivers.

Through its partnership with the AAAs, ADSA operates the Family Caregiver Support Program for individuals 18 and older. Unpaid family and other informal caregivers can access a variety of core services: specialized caregiver information and assistance, training, counseling and support groups, respite care and supplemental services which provide needed supplies or equipment.

DDD operates the Family Support Program to support families caring for a family member with a developmental disability in their own home. The program provides families with supports such as respite care, transportation, specialized aids, and therapies to help continue caring for the family member at home. As mentioned, funding categories can limit access to these supportive services. Families may use the RHC as a respite provider because RHC services are considered "entitlements" and funding for community respite services is limited. This strategic plan includes a proposal to seek increased funding for less costly community respite services for persons with developmental disabilities.

In addition, grandparents and other relatives raising children (known as kinship caregivers) are a fast growing group of caregivers. In Washington State, the 2000 census reported that there were at least 35,341 grandparents who are the primary caregiver for their grandchild(ren). These older adults may not need the traditional long-term care services but they do need support in caring for their grandchildren. The AAAs, along with their subcontracted community agencies provide funds to help with the cost of needed supplies and services, such as housing, food, clothing, supplies, and school activities.

In addition, kinship caregivers often lack knowledge of available support services. Currently a number of Kinship Navigators provide a one stop shop service, along with emotional support to help guide kinship caregiver through challenging times.

Some families with children with developmental disabilities participate in the Voluntary Placement Program which allows birth or adoptive parents to retain custody of their child while participating in shared parenting with foster care providers.

ADSA provides a variety of additional supportive services intended to help prevent the need for future, more expensive services. These services may be contracted through counties, Area Agencies on Aging, private agencies, or individual providers and may include medical, dental, professional therapies, transportation, medically intensive

services, family caregiver support, adult day health, home-delivered or congregate meals, respite care services, nutrition education and health promotion/disease prevention and legal services.

As the numbers of people needing care increases, we anticipate that supports for informal caregivers and the types of other services mentioned above will become even more necessary to help individuals and families to continue to provide for their own needs.

Services focused on monitoring quality, safety, and accountability:

ADSA is responsible for monitoring the quality, safety and accountability of the services provided to Washington State citizens regardless of whether or not those services are paid for by government funds. ADSA licenses all adult family homes, boarding homes, and nursing homes in the state. We also certify Supported Living programs. The administration has delegated authority from the federal Centers for Medicare and Medicaid Services (CMS) to certify nursing homes and Residential Habilitation Centers for the Medicare and Medicaid programs.

The Medicaid program also has certain expectations for state activities to protect the health and safety of people receiving home and community services through Medicaid waivers. These include quality assurance activities and training requirements. ADSA has quality assurance units in the Home and Community Services and Developmental Disabilities Divisions to oversee provider and staff compliance with policy and statutory requirements. However, improvements can be made to these programs.

Licensure and certification inspections of residential facilities are done on a timeframe established in statute. Nursing homes must be inspected at least every 15 months with adult family homes and boarding homes receiving inspection at least every 18 months. Supported Living programs are certified every two years. Inspections are unannounced and they are scheduled so that facilities that have had problems in the past are inspected more frequently.

The ADSA residential licensure and inspection program is held up as a national model. However, improvements can be made. Adult family homes may have fewer outside contacts than larger facilities so ADSA has identified a need for resources to visit newly licensed adult family homes within 90 days to ensure that providers understand and are meeting requirements. Additionally, the quality of nursing homes benefits from periodic visits of Quality Assurance Nurses (QANs) who provide technical assistance. For example, ADSA is currently monitoring improvement in pain management in nursing homes as a result of QAN technical assistance. If resources were available, this program would improve the quality of services in boarding homes and adult family homes.

To be in compliance with federal Medicaid waiver requirements, the state should be providing more training for providers of respite care, alternative living, and Medicaid Personal Care for children. Staff are needed in each region to provide system oversight and management of training and to provide nursing consultation and health services oversight. In the Supported Living program, resources are not currently available to do a follow up visit after a certification inspection to ensure that problems have been corrected. Additionally, supported living providers should be visited more often than every two years to protect vulnerable clients. These more frequent visits would help ensure that any problems with quality of care, quality of life, or safety of clients are dealt with early.

ADSA has responsibility for following up on complaints made about care provided in all settings, regardless of whether the individual receives paid services or not. Timeframes for complaint investigation are established by policy.

ADSA's Adult Protective Services program (APS) receives and investigates complaints of abuse or neglect of vulnerable adults who live in their own homes, regardless of whether they receive long-term care services. APS also investigates complaints when a vulnerable adult resides in a residential setting and the alleged perpetrator is not an employee of the setting. A Vulnerable Adult is defined in statute and includes a person:

- Sixty years if age or older who has the functional, mental, or physical inability to care for himself or herself; or
- Found incapacitated under Chapter 11.88 RCW; or
- Who has a developmental disability as defined under RCW 71A.10.020
- Admitted to any facility; or
- Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or
- Receiving services from an individual provider.

The federal Medicaid program requires states to develop self-monitoring activities for APS programs. This strategic plan includes activities to develop a comprehensive quality assurance system for APS, including FTE and technology needs.

ADSA's Residential Care Services Division (RCS) receives and investigates complaints related to licensed and certified residential facilities such as nursing homes, boarding homes, adult family homes, and supported living.

Complaint investigators work with local law enforcement, the long-term care ombudsman's office, and other local agencies to investigate and resolve problems.

If a complaint is substantiated, ADSA may employ a variety of tools to respond to the problem. Residential facilities may be required to develop a plan of correction as a result of a substantiated complaint. They may also receive a fine, a stop placement, a condition of their license or a license revocation in more serious situations. When a complaint related to a vulnerable adult who lives in his or her own home is substantiated, APS may help the person move to a different care setting, change caregivers, or get a protective order or guardianship. In certain serious situations, an individual caregiver may have their name placed on a registry that will prohibit future employment in long-term care settings.

Typically, the complaint investigation process in a residential facility focuses on whether the facility systems failed to protect residents. In nursing homes, the ADSA Resident Protection Program pursues serious allegations in which an individual employee of the facility is alleged to have caused a resident harm. ADSA would like to expand this program to boarding homes and adult family homes but do not currently have the resources.

National statistics indicate that only one in five allegations of abuse is ever reported. Allegations may relate to serious or life-threatening harm, self-neglect, abandonment, physical or verbal abuse, financial exploitation, or unhealthy living conditions. ADSA has made efforts to encourage reporting of abuse through public awareness campaigns, local training, publishing toll-free complaint phone numbers, and so on. We also work to

prevent abuse through respite and caregiver support programs to help avoid burnout. This strategic plan includes strategies to encourage more reporting of potential problems. It also includes strategies to deal with increasing numbers of complaints.

ADSA has a responsibility to ensure the accountability of its programs. Many of the functions discussed above such as case management, licensure, and complaint investigations have an accountability component. These and other important functions are supported by an infrastructure that helps them accomplish their responsibilities. The infrastructure may include such things as information technology, contracting processes, accounting functions, or supervisory and administrative support. The strategic plan identifies area where these infrastructure functions must be improved to support all of the essential work done by the organization. Some of these strategies include developing improved methods of doing financial oversight of contractors per federal requirements or providing training to supervisors to help them help staff perform better. These areas are not ones that receive a lot of attention from policy makers but they are critical in ensuring that the organization can accomplish important functions.

Another key area of accountability that will continue to require management attention and new resources is the need to develop data systems to keep up with ever changing program improvements and new requirements. We will continue to devote substantial resources to improving our data systems for assessment of client needs and case management. Additionally, as resources become available upgrades are needed for the data systems used to calculate nursing home payments, and systems for planning and tracking residential facility inspections, adult protective services investigations, complaint investigations in residential settings, and the system-wide incident reporting system used in DDD.

Chapter 3 ● Customer Characteristics and an Appraisal of the Changing External Environment

TRENDS IN DEMOGRAPHIC AND CUSTOMER CHARACTERISTICS

For more than a decade, all fifty states have been engaged in an effort to reduce Medicaid reliance on institutional services (e.g., nursing homes and RHCs) and expand home and community options. This effort is the result of a number of factors including the federal Olmstead ruling which requires states to move towards expansion of less restrictive options. Also important is the fact that, for many clients, home and community services tend to be less costly and more preferred than institutional services.

Washington State has been seen as a leader in this effort, reducing the portion of the long-term care budget spent on nursing homes from 82% in FY 91-93 to 45% in FY 05-07. But much work remains to be done.

Individuals are living longer and the population is aging. Advancements are being made in medical technology that result in adults with significant disabilities surviving much longer and successful supports to children with disorders at the time of birth that may previously have proven fatal. Additionally, the incidence of some conditions such as autism and dementia has increased over time.

The "Baby Boomer" generation is not only experiencing the dramatic social, emotional and financial impact of parent care responsibilities but they will soon also begin to look for ways to meet their own long-term care needs. Parents of children with developmental disabilities are increasingly caring for their children at home. More grandparents and other relatives find themselves as primary caregivers to their grandchildren or other kin.

Program experience indicates rising acuity in serving older adults as well as children and adults with disabilities. There are a growing number of high-risk clients with complex medical conditions, prescription drug requirements, cognitive deficits and functional and developmental disabilities. ADSA serves an increasing number of people with highly complex and challenging medical, psychiatric, and behavioral conditions. For example, a 1997 study found that almost half of DDD clients have special needs in addition to their developmental disability, such as community protection issues, mental illness, language or cultural difference, and families who have difficulties coping with these special needs.

Prevalence rates of dementia-related diseases increase with age. The U. S. General Accounting Office (GAO) estimates that 18% of persons over 85 have some level of Alzheimer's Disease and 53% of those over 95 have the disease. Washington State's population over 85 is expected to double between 2005 and 2030. It is estimated that the cost of conditions like coronary heart disease, congestive heart failure or diabetes double when Alzheimer's Disease is also present and that persons with dementia have hospital, home health and skilled nursing facility costs at least three times higher than those without dementia. It will be important for Washington to not only develop the capacity to serve growing numbers of people with dementia-related diseases but to develop and improve programs that coordinate medical, pharmaceutical, long-term care and other support services for this growing population.

Additionally, we are seeing a growing number of individuals needing long-term care or services for persons with developmental disabilities who come from correctional facilities, the Special Commitment Center, or other parts of the judicial system. Services for these individuals must be specialized to provide for their needs and civil rights while also protecting others with whom they live and their communities.

All these factors have resulted in a growing number of persons living with chronic illness, cognitive impairment, and developmental and functional disabilities who require assistance. The primary resource for long-term care continues to be family and friends.

Growth in the population needing care and smaller family size in the "baby boom" generation has combined to decrease the ratio of caregivers to those needing care. It is estimated that in 1990, there were eleven potential caregivers for each person needing care. By 2050, that ratio will be four to one.

The result of all these factors is that more support is being provided by everyone. Individuals with disabilities are finding a need to adapt to and address their own needs for much longer periods of time. Families are providing more support but the capacity of families to support a member needing care varies greatly. The result is an increasing demand for improvement and expansion of the state long-term care system to support and complement the ability of people with disabilities to care for themselves, and to enhance and sustain the ability of informal caregivers to help.

The aging of the Baby Boomer generation will greatly increase the numbers of Washingtonians needing long-term care. Office of Financial Management forecasts rapid growth in the state's 65+ population beginning in 2005. The 65+ population is estimated to have been 696,555 in 2004 and is expected to grow to 812,200 in 2010; 1.2 million in 2020; and 1.6 million in 2030. It is less clear how disability rates or individual's ability to pay for their own long-term care needs may change over time.

Discussions are ongoing in Washington and in the nation about how to prepare for an enormous increase in the number of people needing long-term care in the next 30-40 years. Clearly, the Medicaid program alone will not be able to absorb the growth in this need, even if the program focuses on serving individuals in the least costly settings that are appropriate to their needs. Multi-part strategies are needed that should include increasing the total amount, efficiency, effectiveness of the Medicaid contribution toward this demand; building and strengthening services outside of Medicaid, strengthening supports to informal caregivers, encouraging prevention and early intervention strategies, and encouraging individuals to plan and pay for their own long-term care needs.

Customer Characteristics

ADSA's customers include individuals who range in age from newborns to the oldest Washington State residents. Some customers receive only information or service coordination from ADSA. Some benefit from the quality assurance activities that ADSA conducts in residential facilities. Some individuals have their long-term care needs paid for in whole or in part through ADSA.

Individuals needing long term care and supportive services require a complementary set of medical, prescription drug, personal care, and supportive services. ADSA is working with DSHS partners to coordinate services through the Washington Medicaid Integration Project (WMIP) project. We will be evaluating whether the chronic care management

provided in WMIP result in; better coordination of care, better client outcomes, and improved cost-effectiveness. Additionally, ADSA has developed the CARE assessment instrument to better meet the need for holistic care planning. Several intensive, chronic care case management projects are also underway that build on ADSA's existing casework infrastructure and, like WMIP, will be tested to determine if they provide better coordination of care, better client outcomes, and cost-effectiveness.

In addition to the increasing complexity of client needs, coordination of services for clients is becoming more complex. For example, helping clients understand the benefits available to them under Medicare Part D, Veteran's programs, Social Security, or local property tax exemptions for disabled adult children could consume enormous amounts of social worker and case manager time. The programs can be very beneficial for the client and could perhaps save state money but workers often do not have the time or expertise to fully explore all the available options.

As the Medicaid nursing home caseload decreases, the natural tendency of budget makers has been to reduce the number of staff devoted to helping people in nursing homes to identify other options. However, recent data indicates that the number of people entering nursing homes is not decreasing. This may be in part due to increasing disability levels and complexity of client needs. In order to maintain a downward trend in the nursing home Medicaid caseload, ADSA will require a continued case management strong presence in the nursing homes. This strategic plan includes strategies to provide the infrastructure needed for staff to accurately analyze individual's needs, identify untapped supports, and help identify any appropriate additional services.

Data on individuals who receive paid services from ADSA indicates that our client base is at least as diverse as Washington's population. For example, African Americans represented about 3.5% of Washington's population in the 2000 federal census but made up a larger percentage of the ADSA service population in 2004 (3.7% in nursing homes and 6.7% in Medicaid Personal Care). However, there are areas where we must assess whether more effort is necessary to provide culturally and ethnically appropriate services. Asian and Pacific Islanders are slightly underrepresented in the COPES waiver (4.2% of the COPES population compared to 6.4% of Washington's population). However, Asian and Pacific Islanders make up almost 23% of the Medicaid Personal Care population.

ADSA strives to serve individuals in the settings that they prefer, usually in their own home or community. However, we also recognize the need to make institutional services such as nursing homes and RHCs available when they are needed and wanted by the individual. Some minority groups are slightly underrepresented is the nursing home Medicaid caseload. Native Americans make up 1.7% of Washington's population and 1.6% of the nursing home Medicaid caseload. Additionally, Asian and Pacific Islanders make up 6.4% of Washington's population but only 2.8% of the nursing home Medicaid caseload. The RHC census shows a smaller percentage of minority clients served than are represented in the general population. We hesitate to establish goals to increase services to diverse populations in these institutional settings since this is typically not a service the individual desires. ADSA's goals in the area of serving more diverse populations center around ensuring that preferred home and community services are available.

This plan includes strategies to improve access to community residential services in rural areas. Boarding homes and adult family homes have been slower to develop in rural areas, perhaps because they are typically smaller than a nursing home and may have

more difficulty attracting consumers from distant communities than rural nursing homes do. Additionally, many adult family homes in urban areas are operated by ethnic minorities. The plan includes strategies to work with minority populations in rural areas to encourage development of adult family homes. An area in which we hope to make gains in improving services is in our work with tribes to increase community residential resources and provide education on self-direction opportunities.

A recent policy change that is reflected in the strategies in this plan is the expansion of chemical dependency treatment. Authorized in the 2005 legislative session, this is an exciting opportunity for long-term care clients. Many clients have long-standing chemical dependency issues that impact their health and activities of daily living but these individuals have not historically had access to treatment. We anticipate that having treatment available for these people will help some reduce or avoid the need for long-term care services. However, two resource issues associated with this project have emerged. First, the Legislature removed $6.8 million from the FY 05-07 ADSA budget under the assumption that expansion of chemical dependency treatment would help reduce the nursing home caseload by 42 in FY 06 and 110 in FY 07. In practice, the program is targeting individuals who are not receiving nursing home services. While expanded treatment may help divert some people from ever needing nursing home care, there is no way to document the number of cases that might have needed nursing home care had they not received chemical dependency treatment.

Additionally, implementation of expanded chemical dependency treatment programs will require additional efforts and new working relationships on the part of everyone involved. Social workers, case managers and treatment program staff will need to build relationships and share information and education about chemical dependency programs and specific needs of elderly and disabled clients. There will have to be a way to track referrals, participation in programs, and the progress of ADSA clients. The special needs of elderly and disabled clients will also require new efforts to educate long-term care providers about the signs of chemical dependency, develop transportation systems that can take long-term care clients to treatment providers, and so on. While ADSA management and staff are committed to making this program a success, no resources were provided to ADSA to assist in that effort.

POTENTIAL CHANGES IN ENVIRONMENT THAT CAN AFFECT CLIENTS' NEEDS

Competing demands for limited funds have spurred discussions about changes in policy and funding for long-term care nationally and within Washington State. Wars, tax cuts, natural disasters in the southeast, and implementation of Medicare Part D have all stretched the resources of the federal government. Additionally, the rapid growth of the Medicaid program has been a topic of national concern. As a result, a number of proposals have been put forward to reduce Medicaid expenditures. In the long-term care program, proposals have focused on reducing the individual's ability to transfer or shelter assets in order to become eligible for Medicaid and looking at stricter audit requirements for providers of home and community services in order to reduce cost. Longer term effort on the part of the federal government includes developing pilot projects to encourage individuals to plan for their own long-term care needs rather than relying on government programs.

In Washington State, policymakers have addressed their concerns about the state's ability to fund long-term care programs into the future by establishing a Long-Term Care Task Force that will look at alternative financing systems.

A relatively recent trend in the external environment that will impact long-term care in Washington State is the strong union representation of individual provider/home care workers. The 2005-07 state budget makers were required by law to consider the collective bargaining agreement negotiated between home care workers and the Governor's Office. Collective bargaining by workers has resulted in improved wages, benefits, and working conditions – a positive outcome for long-term care programs. However, this also puts upward pressure on the cost of care. Several years ago, the average per capita cost of an in-home Medicaid client was 25% of the average nursing home cost. Increased case complexity that requires more hours of care per person has combined with increased wages and benefits to increase that to 33% of the average nursing home cost in November 2005.

Wage and benefit increases for the in-home workforce that must, by statute, be included in the Governor's budget will compete with other needed enhancements identified elsewhere in this plan. Additionally, since residential care and home care compete for the same workforce, increases to wages in one area have a significant relationship to the ability of the other to attract workers. This could have a destabilizing influence on ADSA's ability to maintain a range of home and community services that are adequate alternatives to institutionalization. As upward cost pressure continues, policy makers will be required to balance appropriations for wage and benefit improvements for the workforce in parts of the system with the impact on other parts of the system, with other needed improvements.

Chapter 4 ● Goals, Objectives, Strategies and Performance Measures

Goal 1: Maintain an appropriate balance between institutional services and home and community services.

Objective 1: Reduce nursing home caseload to 10,500 by FY 11.

Strategies:
- Continue to assist individuals and families to identify preferred alternatives.
- Develop QA monitoring system targeted to Nursing Facility Case Managers.
- Develop data reports showing where nursing home placements come from and where discharges go to help target relocation efforts.
- Develop systems to reduce barriers to nursing home relocation.
- Work with the Department of Health, nursing home associations, stakeholders to review the nursing home bed need formula in light of significant numbers of empty beds.
- Request FTEs needed to assess dual-eligible individuals who enter nursing homes under Medicare to help identify home and community options before the person converts to Medicaid.

Performance Measures:
- **Nursing home caseload** (activities: E064 Nursing Home Services).

Objective 2: Manage the census of the Residential Habilitation Centers within budget

Strategies:
- Continue to offer least restrictive settings to clients.
- Continue management review of new RHC placements to ensure compliance with census expectations in the FY 05-07 budget.

Performance Measures:
- **RHC census** (activities: D036 DD Field Services, D086 RHC).

Objective 3: Payment methodologies are fair and consistent and encourage service in appropriate settings.

Strategies:
- Complete and implement standardized rates for supported living and DD group homes.
- Complete a study of adult family home costs to determine if ratio of payment rates to costs are consistent with boarding home rates and costs.
- To the extent possible, adjust program expectations or request funding for rate increases for vendors with rates more than 10% lower than appropriate market levels.
- Participate in MMIS re-procurement.
- Develop budget-neutral nursing home payment proposal that focuses more funds on direct care services.

- Request funding for a re-write of the Nursing Facility Information System that supports nursing home payment system.

Performance Measures:
- Standardized rates are in place for supported living & DD Group homes (activities: D079 Program Support for DD, D087 Residential Program, E051 LTC Administration.

Objective 4: Expand the types of home and community services that are available and access to those services.

Strategies:
- Assist rural communities to expand community residential resources.
- Work with AAAs to improve rural access to home care and other COPES-funded support services.
- Work with tribes to develop residential resources.
- Develop community resources to for specialty services such as services for individuals with Traumatic Brain Injuries, chemical dependency needs, mental health needs, behavioral issues, dementia etc.
- Work to make Medically Needy waivers equal to the COPES waiver regarding the personal needs allowance and spousal deeming.
- Assess expansion of adult day health/adult family home pilot.
- Expand number of people who use in-home nurse delegation.
- Pursue new technologies to improve client outcomes.
- Pursue funding and necessary legislative authority to develop an emergency, short-term community respite service for persons with developmental disabilities.
- Request growth in Basic and Basic Plus Waivers to help individuals avoid out-of-home placements.

Performance Measures:
- **Percent of LTC clients served in home care and residential settings** (activities: E051 LTC Administration, , E050 LTC Adult Family Home Community Services, E052 LTC Eligibility/Case Management Services, E055 LTC Residential Community Services. E053 LTC In-Home Services).
- **Average cost per LTC case** (activities: E051 LTC Administration, E050 LTC Adult Family Home Community Services, E052 LTC Eligibility/Case Management Services, E064 Nursing Home Services, E055 LTC Residential Community Services. E053 LTC In-Home Services).
- **Percent of DD clients served in home/community settings** (D028 Employment and Day Programs, D036 DD Field Services, D070 Other Community Programs, D074 DD Personal Care, D076 Professional Services, D079 Program Support for DD, D083 Public Safety Services, D034 Family Support Program for DD Clients, D087 DD Residential Programs).
- **Average cost per DD case** (D028 Employment and Day Programs, D036 DD Field Services, D070 Other Community Programs, D074 DD Personal Care, D076 Professional Services, D079 Program Support for DD, D083 Public Safety Services, D034 Family Support Program for DD Clients, D087 DD Residential Programs, D086 Residential Habilitation Facilities, D095 State Operated Living Alternatives).
- **Number of Allen-Marr class members re-admitted to a state hospital.**
- **Length of stay in the community for Allen-Marr class members served in community settings.**

Objective 5: Improve the readiness of ADSA programs to address the needs of a growing dementia population

Strategies:

- Incorporate strategies that preserve brain health
- Advocate to reach dementia caregivers early to encourage LTC planning
- Partner with physicians and health care organizations for better overall/coordinated care
- Encourage family caregivers to use respite and support services earlier in the disease process
- Provide services that are known to delay nursing home placement for people with dementia.

Performance Measures:

- Percent of persons with dementia diagnoses that are served in home and community settings (activities: E051 LTC Admin, E052 LTC Eligibility/Case Management Services, E050 LTC Adult Family Home Community Services, E055 LTC Residential Community Services. E053 LTC In-Home Services)

Objective 6: Ensure that services appropriately address client needs

Strategies:

- Continue to make improvements to assessment through the CARE tool, such as changing the algorithm for behaviors, to ensure client needs are adequately addressed.
- Continue development of Case Management Information System for DD programs; bringing together a variety of fragmented data systems, increasing management reporting capability, and connecting to ProviderOne payment system.
- Provide easy-to-access training for social workers and case managers on topics such as chronic care interventions, evidence based protocols, medical social work skills, effectively communicating with clients, working with clients with secondary disabilities, assistive technology, and independent living services.
- Complete plans of care on time for all waiver clients.
- Complete annual CARE reviews for Medicaid Personal Care clients.
- Request funding to improve or at least maintain caseload ratios for HCS/AAA/DDD – particularly for complex clients in both LTC and DD programs; to implement annual plan of care reviews and mini assessment for individuals with developmental disabilities; to implement new policy of reduced caseload ratios for community protection program; and to do 30-day visits for children with developmental disabilities in out-of-home placements.
- Continue to improve partnerships with AAAs to ensure new and existing roles are coordinated and focused on improving client services.
- Continue to improve partnerships with advocacy groups to ensure that the services being offered by DDD are consistent with community needs.
- Develop and share data on all Medicaid services for MPC/waiver clients to help manage all Medicaid costs.
- Fully implement QA protocols for HCS, DD, AAAs and APS.
- Request necessary additions to Office of Decision Support to provide data to help identify client needs.

Performance Measures:

- **Percent of waiver plans of care done on time** (activities: E051 LTC Admin, E052 LTC Eligibility/Case Management Services, D036 DD Field Services).
- Percent of annual CARE reviews done on time (activities: E051 LTC Admin, E052 LTC Eligibility/Case Management Services, D036 DD Field Services).
- Ratio of social workers/case managers to cases (activities: E051 LTC Admin, E052 LTC Eligibility/Case Management Services, D036 DD Field Services).

Objective 7: Improve public and individual safety

Strategies:

- Request more funding for Community Protection Program slots.
- Request funding to improve caseload ratio in Community Protection Program.
- Request legislation and necessary funding to make background check requirements for Individual Providers consistent between LTC and DDD programs.
- Develop program to serve individuals leaving correctional facilities or the Special Commitment Center who are in need of long-term care.

Performance Measures:

- % of quarterly case reviews completed on time in Community Protection Program (activities: D079 Program Support for DD, D036 Field Services, D082 Public Safety Services).

Objective 8: Leave no major cultural or linguistic group behind

Strategies:

- Make translation or alternative formats of material an equal priority with preparation of materials in English.
- Actively include consultation with affected minority groups in development of policies and programs.
- Utilize professional interpreter services for spoken and sign languages where bilingual staff is not available.
- Provide supervisors with a list annually of staff who have not completed required diversity training.
- Provide quarterly reports to supervisors of their workforce profile to determine whether there are under-represented groups.
- Work with supervisors to develop action plan for improving workforce profile.
- Continue to educate ADSA offices about the Supported Employment program and encourage hiring of individuals in the Supported Employment program.

Performance Measures:

- Number of alternate formats available (activities: E051 LTC Administration).
- % improvement in the numbers of staff who have completed required diversity training (activities: E051 LTC Administration, E052 LTC Eligibility/Case Management Services, D036 Field Services)

Objective 9: Improve disproportionality rates in at least one client service

Strategies:

- Work with tribes to increase community residential resources.

- Continue to develop residential service options for the increasing numbers of clients who are non-English speaking.
- Work with tribes to educate case management staff and people with disabilities living on tribal land of their right to self-directed their care.

Performance Measures:
- % growth in number of tribes offering community residential resources (activities: E051 LTC Administration, E050 LTC Adult Family Home Community Services, E052 LTC Eligibility/ Case Management Services, E055 LTC Residential Community Services).
- % growth in number of tribes offering in-service training about self-directed care (activities: E051 LTC Administration).

Goal 2: Support families of persons with disabilities and older persons to provide long-term support through caregiver assistance, respite and family support.

Objective 1: Support Unpaid Family Caregivers

Strategies:
- Continue participation in the national family caregiver research assessment project (through University of Wisconsin) to improve WA State's caregiver assessment procedures.
- Ensure that culturally appropriate services are available to family caregivers.
- Integrate family caregiver services within the HCS service system.
- Train HCS and AAA staff to better screen/assess family caregivers.
- Implement the new Dementia Partnerships Projects.

Performance Measures:
- % growth in number of people served in caregiver support and respite programs.
- % growth in number of person participating in the Dementia Partnership Projects core services; dementia day services, caregiver consultation and counseling.

Objective 2: Support and Empower Kinship Care Families

Strategies:
- Continue Collaboration with ESA and CA to provide resource information about available services to kinship care families and their advocates.
- Continue work with the WA State Kinship Oversight Committee and the DSHS Kinship Task Force to strengthen and expand kinship services and resources.
- Strengthen the Kinship Caregivers Support Program service delivery protocols in conjunction with AAAs.

Performance Measures:
- % growth in requests for information (new DSHS kinship webpage hits, resource booklets and brochures disseminated by Department of Printing).
- Number of persons trained in statewide satellite broadcast kinship conference.
- Number of persons served with emergent funding.

Objective 3: Training programs are available to improve caregiving

Strategies:
- Continue to provide family caregiver training

- Develop education models related to appropriate prescribing behaviors for seniors.
- Develop education models to help clients/families manage disabilities over long period of time.
- Partner with the Arc of Washington in providing training and information to senior families caring for adults with developmental disabilities in their homes.
- Provide statewide conferences on supported employment and residential issues that include both providers and family members.
- Request funding for training of providers of respite care, alternative living, and Medicaid Personal Care for children to meet federal requirements.
- Request FTEs to provide system oversight and management of training in each region.

Performance Measures:
- Education models developed related to appropriate prescribing behavior for seniors (activities: E051 LTC Administration).
- Yearly conferences on supported employment and residential services are attended by increasing numbers of family members and participants (activities: D079 Program Support DD).

Goal 3: Expand our vision to help Washington's citizen's plan for future care needs, participate in their own care, engage in health promoting behaviors, and benefit from early interventions.

Objective 1: Partner with other state agencies, local lead agencies and community resources to continue to provide and improve the Infant Toddler Early Intervention Program.

Strategies:
- Participate in Washington Learns Initiative to provide input & recommendations for ways to improve early intervention programs.
- Pursue research opportunities with OSPI to identify the impacts of early learning on children's learning successes in later years.
- Partner with OSPI to quantify the costs and benefits of early learning programs.
- Align the movement of the ITEIP program with the Governor's priorities.

Performance Measures:
- **Percent of children who leave the ITEIP program at age three who no longer need special education services** (activities: D044 Infant Toddler Early Intervention Program).

Objective 2: Washington's citizens should understand the long-term care options available to them so they can plan for their own needs.

Strategies:
- Participate in LTC Task Force.
- Provide Information & Assistance (I & A) through Area Agencies on Aging to senior citizens and their families.
- Expand I & A to other populations such as the younger disabled and for more people through the Aging and Disability Resource Center grant.
- Build and strengthen additional supportive services outside of Medicaid.
- Build relationships with employers to help them understand need for LTC planning.

- Work with DOH to develop proactive, preventative care advocacy.
- Partner with the Developmental Disabilities Endowment Trust Fund in helping families realize the necessity of preparing financially for the future of their son or daughter with a developmental disability.
- Survey families in which aging parents are caring for their adult children with developmental disabilities to determine if the families have plans in place or need assistance with planning.
- Partner with the Developmental Disabilities Council in establishing lines of communication to families and individuals with developmental disabilities on the services provided by DDD as well as providing information to help them maximize their ability to support family members.
- Seek adequate funding for and implement flexible caregiver, family caregiver support, and respite programs.
- Pursue federal funding to participate in the LTC Awareness Project.

Performance Measures:
- Number of new non-Medicaid services developed (activities: E051 LTC Administration, E052 LTC Eligibility/Case Management Services).
- Washington's scores on the National Core Indicator surveys for families, consumers and children improve on 6 questions by the end of the State Plan (activities: D079 DD Program Support).

Objective 3: Improve consumer independent living skills and ability to direct their own care.

Strategies:
- Create a flexible system through the New Freedom Waiver that encourages independence.
- Develop a person centered planning instrument, which will enhance the person's ability to direct their individual budgets.
- Provide independent living consulting services and fiscal intermediary services to assist the individual in developing and implementing the budget established in the plan.
- Continue to provide and expand the self-directed care option to people with functional disabilities in the home setting.

Performance Measures:
- **Average cost/case of home and community clients** (activities: E051 LTC Admin, E052 LTC Eligibility/Case Management Services, E055 LTC Residential Community Services, E053 LTC In-Home Services).
- % growth in number of individuals participating in New Freedom waiver, self-directed care, independent living (activities: E051 LTC Admin, E052 LTC Eligibility/Case Management Services, E055 LTC Residential Community Services, E053 LTC In-Home Services).

Objective 4: Medicaid clients contribute to the community to the extent they desire and are able.

Strategies:
- Implement DDD Working Age Adult policy to provide employment programs for persons with developmental disabilities.

- Support the efforts of the Developmental Disabilities Life Opportunities Trust Fund to inform families and participants of the opportunity to establish trusts for their sons and daughters or themselves.
- Support the efforts of the Developmental Disabilities Life Opportunities Trust Fund to inform families and participants of the opportunity to establish trusts for their sons and daughters or themselves.
- Develop data system to leverage SSI/SSA benefits that may be available to help individuals pay for their own care.
- Request authorization and funding to make the Personal Needs Allowance the same for COPES and Medically Needy In-Home waiver clients.

Performance Measures:
- **Percent of DDD waiver clients employed or participating in employment programs** vs. community access programs (activities: D028 Employment & Day programs).
- Total wages earned by DDD clients (activities: D028 Employment & Day programs).

Goal 4: Improve upon the already strong performance of programs that monitor the quality of care, quality of life, safety of vulnerable children and adults, and accountability.

Objective 1: Maintain compliance with established timeframes for complaint investigation

Strategies:
- Monitor and analyze complaint investigation workloads and pursue additional resources as needed.
- Continue to monitor compliance with timeframes and require local investigation of any failures to comply.
- Coordinate complaint investigation and certification activities for Supported Living program through movement of complaint investigation function to RCS.
- Monitor frequency of reported complaints regarding supported living providers and request FTEs to do supported living complaint intake and investigation if necessary.

Performance Measures:
- **Percent of APS complaints responded to timely** (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).
- **Percent of residential complaints responded to timely** (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).

Objective 2: Intervene to prevent abuse/neglect/exploitation to the extent we are legally authorized

Strategies:
- Fund AAA caregiver support and elder abuse prevention programs.
- Continue to promote opportunities for public to learn about ways to prevent abuse (caregiver conference, caregiver month, adult abuse prevention month).
- Enhance consistency in implementation of APS policies and procedures across regions by revising Chapter 6 of the Long-Term Care Manual, revising the Training Academy curriculum, retraining all APS workers, and requesting FTEs to establish a quality assurance monitoring program for APS.

- Develop legislative and budget request for FY 07-09 to expand Resident Protection Program to adult family homes and boarding homes to investigate allegations of abuse by an individual and place names of confirmed abusers on registry prohibiting future employment.
- Work with Attorney General's Office to request additional resources and Attorney General FTEs to support guardianship program.
- Work with Community, Trade, and Economic Development to request additional resources for LTC ombudsman to be a stronger presence in adult family homes and boarding homes.
- Implement an anti-Financial Exploitation initiative through request legislation that would make banks mandatory reporters of suspected financial exploitation, modify the definition of financial exploitation, and require mandatory reporters to provide APS with requested records related to the financial exploitation allegation under Chapter 74.34 RCW.
- Improve data systems used to track and manage adult protective services cases, complaints in residential facilities, and incidents reported for people with developmental disabilities.
- Implement new statutory certification standards for residential providers serving persons with developmental disabilities.

Performance Measures:
- % of APS QA reviews indicating consistent policy/procedure implementation statewide (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).
- Number of persons referred to registries (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).
- Percent of residential providers in LTC and DD settings that do not have an enforcement action taken against them (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).

Objective 3: Maintain compliance with timeframes for re-inspection of residential facilities.

Strategies:
- Prioritize re-inspection process when staff reductions occur.
- Improve information system used to monitor re-inspection frequency to focus on early re-inspections for poor performers and new providers.
- Improve timeliness of AFH licensing process.
- Request funding for contracted Evaluators to do re-visits and shorter certification periods for Supported Living providers experiencing care problems.
- Request funding for visits to newly licensed adult family homes 90 days after licensure to ensure that providers understand and comply with requirements.

Performance Measures:
- **Percent of inspections done timely** (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).
- Percent AFH license actions complete within 60 days of receipt of complete application (activities: E050 LTC Adult Family Home Community Services, LTC Investigations/Quality Assurance).

Objective 4: Provide necessary consultation for providers

Strategies:
- Have QANs regularly assess and analyze clinical protocols that incorporated federal quality indicators.
- Request FTEs to create a QAN-type program in boarding homes and adult family homes.
- Request FTEs to perform 90-day visits in adult family homes.
- Request FTEs for nursing care consultants to do client consultation and health services oversight in DDD.

Performance Measures:
- For NH residents with pain, percent reviewed by QAN where it is determined that pain is being assessed and managed properly (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).
- Percent of Medicaid-certified nursing homes with quarterly protocol visits (activities: E051 LTC Administration, E054 LTC Investigations/Quality Assurance).

Objective 5: Standardize contract monitoring to ensure that providers understand and comply with contract requirements.

Strategies:
- Continue to update and revise standards of operation for providers. Update standards for DD home care agency providers, DD nursing services, nurse delegation and private duty nursing.
- Request necessary FTEs to meet contracting requirements.
- Request statutory change and necessary funding to make background check requirements consistent for DDD and LTC programs.

Performance Measures:
- Percent of providers who comply with contract requirements (activities: D074 DD Personal Care, D076 Professional Services; X48 Private Duty Nursing; X62 Adult Family Homes).

Objective 6: Strong financial oversight is in place

Strategies:
- Request necessary resources to upgrade financial oversight of home and community providers per federal requirements.
- Develop necessary audit procedures for supported living providers.
- Request necessary FTEs to enhance sub-recipient monitoring and to comply with accounting requirements of increasing numbers of grants.
- Centralize certain financial operations and standardize accounting processes to gain efficiencies and ensure correct, consistent accounting.
- Implement spending plan for DD programs to avoid overexpenditure.

Performance Measures:
- Financial oversight of home and community service providers passes any federal audit (activities: E051 LTC Administration).

Goal 5: Continue to develop programs to respond holistically to individual needs.

Objective 1: Develop Integrated Service Programs.

Strategies:

- Continue collaboration with Health and Recovery Services Administration to develop and evaluate WMIP and MMIP and build risk adjusted rates for these service delivery models to avoid adverse selection to the department or the provider.
- Participate in the Governor's 5/50 project and the chronic care activities of the LTC Task Force.
- Continue work on Medicare/Medicaid Integration Project.
- Work with Health and Rehabilitative Services Administration to begin to include Long-Term Care services in WMIP program.
- Expand Chronic Intensive Case Management programs to more sites and, eventually statewide.
- Assess feasibility of expanding PACE program.

Performance Measures:

- Number of LTC clients served in WMIP/MMIP (activities: E049 Adult Day Health Community Services, E050 LTC Adult Family Home Community Services, E051 LTC Administration, E052 LTC Eligibility/Case Management Services, E053 LTC In-Home Services, E055 LTC Residential Community Services, E064 Nursing Home Services).
- Reduction in per-capita health costs of clients in integrated programs, their health system interactions, and improvement in health outcomes (activities: E049 Adult Day Health Community Services, E050 LTC Adult Family Home Community Services, E051 LTC Administration, E052 LTC Eligibility/Case Management Services, E053 LTC In-Home Services, E055 LTC Residential Community Services, E064 Nursing Home Services).

Objective 2: Increase Community Services for People with Mental Illness and Long-Term Care Needs.

Strategies:

- Create client criteria for Enhanced Services Facilities (ESF). Request statutory changes, if necessary.
- If funded, develop two Enhanced Services Facilities – one for persons with developmental disabilities and one for persons with long-term care needs.
- Expand availability of Expanded Community Services (ECS) for persons needing long-term care and mental health services.
- Develop and implement Traumatic Brain Injury (TBI) waiver to support resources for TBI clients currently in state hospitals.

Performance Measures:

- Number of Expanded Community Services programs in operation (activities: E051 LTC Administration, E052 LTC Eligibility/Case Management Services, E055 LTC Residential Community Services).

Objective 3: Persons with Chemical Dependency Needs Receive Appropriate Services.

Strategies:

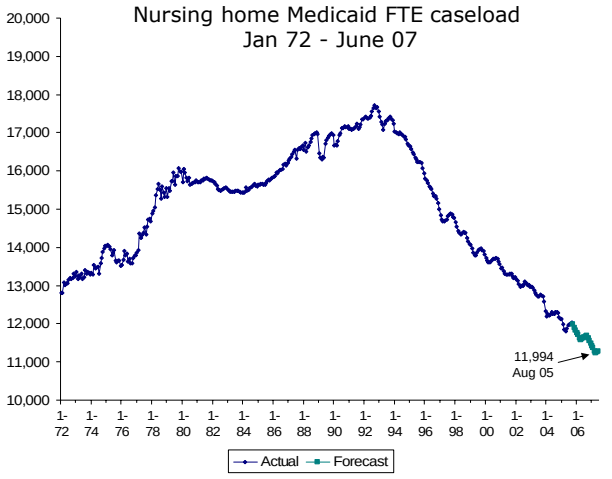
- Participate in Bridging the Treatment Gap program. Assess LTC & DD clients' needs for chemical dependency treatment and refer to chemical dependency providers. Follow up to determine if referral is successful.

Performance Measures:

- Numbers of assessments of clients needing chemical dependency services (activities: D036 DD Field Services, E052 LTC Eligibility/Case Management Services, E064 Nursing Home Services).
- Number of referrals to chemical dependency services (activities: D036 DD Field Services, E052 LTC Eligibility/Case Management, E064 Nursing Home Services).

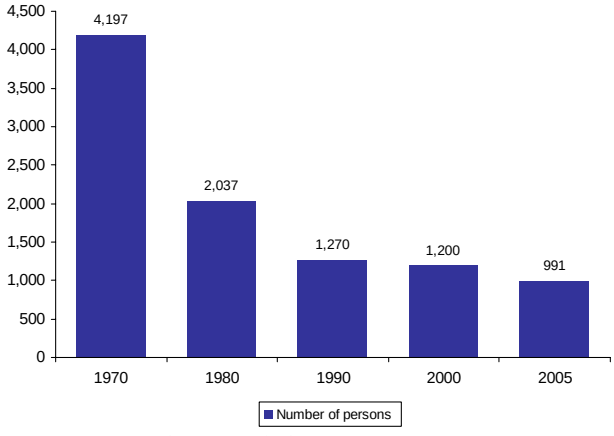
Chapter 5 – Snapshot of ADSA's Core Services

The Medicaid nursing home caseload has declined as a result of efforts to offer home and community services



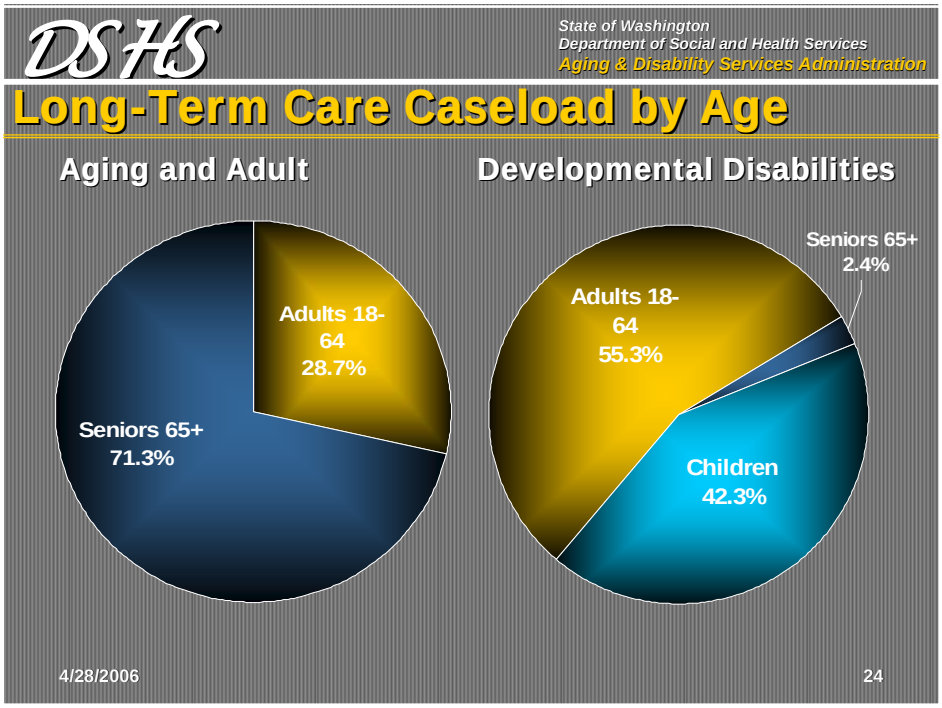
SOURCES: MMIS, EMIS Dec 2005

Persons in Washington state's DD institutions



Data note: 2005 data point is calendar year average

SOURCE: DDD HISTORICAL FILES, EMIS


DSHS
State of Washington
Department of Social and Health Services
Aging & Disability Services Administration
Long-Term Care Caseload by Age
Aging and Adult
Adults 18-64 28.7%
Seniors 65+ 71.3%
Developmental Disabilities
Seniors 65+ 2.4%
Adults 18-64 55.3%
Children 42.3%
4/28/2006
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DSHS Aging and Disability Services Administration

Developmental Disabilities Services

Adult programs

Services	Number of clients (Oct 05)	Average monthly cost per client (Oct 05)
Employment Programs: Includes Community Access, Group Supported Employment, Individual Employment, Pre-vocational Employment	6,135	$494
Family Support	1,902	$262
Medicaid Personal Care (non-residential)	3,200	$937

SOURCES: CCDB, EMIS, ADSA RATES JAN 2006

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DSHS Aging and Disability Services Administration

Developmental Disabilities Services

Children's programs

Services	Number of clients (Oct 05)	Average monthly cost per client (Oct 05)
Child Development Services	1,865	$226
Family Support	1,754	$283
Medicaid Personal Care (non-residential)	1,749	$788
Medically Intensive Services	206	$10,000 RN rate = $31.80 hour LPN rate = $24.52 hour
Voluntary Placement / Foster Care Program	124	$830

SOURCES: CCDB, EMIS, ADSA RATES JAN 2006

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DSHS Aging and Disability Services Administration

Developmental Disabilities Services

Community residential settings

Setting	Number / Size of programs (Oct 05)	Number of clients (Oct 05)	Average monthly cost per client (Oct 05)
Alternative Living	142 providers	350	$435
Community ICFMR	8 facilities Average 7 adults per facility	58	$6,508
Companion Homes	33 providers	36	$4,155
Group Homes	50 facilities 4 - 20 adults per facility	387	$3,829
Residential Habilitation Centers	5 facilities ranging in size from 48 - 395 residents (counts include respite)	981	$13,357
State Operated Living Alternative	Several persons live together as roommates to share living expenses and staff support (24/7 support)	111	$8,322
Supported Living	142 contracted providers - Several persons live together as roommates to share living expenses and staff support (daily to 24/7 support)	3,488	$5,302

SOURCES: CCDB, EMIS, ADSA RATES JAN 2006

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DSHS Aging and Disability Services Administration

Long-term Care Services Settings

Setting	Number / Size of facilities (Oct 05)	Number of residents (Oct 05)	Rate range
Adult family home	2,348 licensed facilities Average 5.5 beds	3,812 state-funded residents 12,873 licensed beds	$45.90 to $87.15 per day
Boarding home: (Assisted Living, Adult Residential Care, Enhanced Adult Residential Care)	549 licensed facilities Average 47 beds	6,360 state-funded residents 26,054 licensed beds	$45.27 to $101.84 per day
In-home	N/A	26,596 state-funded clients	$9.20 to $15.28 per hour
Nursing home*	252 facilities Average 89.8 beds	11,977 state-funded residents 22,723 licensed beds	$146.78 average per day

SOURCES: ADSA FACILITY DATABASE, MMIS, SSPS, EMIS, ADSA RATES JAN 2006

*Nursing homes that are Licensed and Certified, Licensed only, and Hospitals with long-term care wings

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This document is also available electronically at:
www1.dshs.wa.gov/strategic

Persons with disabilities may request a hard copy by contacting DSHS at: 360.902.7800, or TTY: 800.422.7930.

Questions about the strategic planning process may be directed to DSHS Constituent Services at: 1.800.737.0617.

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